



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LAS PALMAS MEDICAL CENTER
PO BOX 1866
FORT WORTH TX 76101

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-06-3377-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier denial reason invalid."

Amount in Dispute: \$37,612.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please find attached the EOBs which issued timely within 45 days of receipt. These denial provided sufficient explanation to allow the sender to understand the reasons for the insurance carrier's actions."

Response Submitted by: Crawford & Co., Harris & Harris, P.O. Box 162443, Austin, TX 78716-2443

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2005 through January 20, 2005	Inpatient Services	\$37,612.64	\$1,118.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the reimbursement guidelines for inpatient hospital services.
3. 28 Texas Administrative Code §134.800, effective July 11, 2004 requires health care providers to submit medical bills for payment on standard forms used by the Centers for Medicare and Medicaid Services (CMS).

4. This request for medical fee dispute resolution was received by the Division on January 18, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on January 30, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated February 16, 2005

- X20-Documentation shows hospital stay exceeds 23 hours.
- Z14-Recommendation of payment has been based on this procedure code which best describes services rendered.
- ZLG-This bill has been reviewed by a registered nurse.

Explanation of Benefits dated February 18, 2005

- F-Reduction according to fee guidelines.

Explanation of Benefits dated March 1, 2005

- U8D, XM9-This item was previously submitted and reviewed with notification of decision issued to payor/provider (Duplicate Invoice).

March 2, 2005, letter to requestor from Crawford & Co.

"Thank you for submitting a corrected claim for the Observation Care; however, the documentation on the EOB lists 30 hours of observation care.

According to the Texas Administrative Code (09/24/2004)

Inpatient Services-Health care, is defined by the Texas Labor Code, § 401.011 (19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital whose length of stay exceeds 23 hours in any unit of the acute care hospital.

Therefore my recommendation is that Las Palmas Medical Center needs to submit a corrected claim (inpatient; bill type 111) with a Room and Board Line so this bill can be reimbursed at the per diem rate.

If you feel that this is a billing error, please send the entire medical record for review so that clarification of the inpatient/outpatient status can be reviewed. When submitting the medical records, please include the following:

Implant invoices and intra-operative implant records (tic sheets)."

Explanation of Benefits dated March 11, 2005

- Upon reconsideration of this bill, the above reimbursement determination has been made. The previous audit determination for this bill was \$0.00.
- X20-Documentation shows hospital stay exceeds 23 hours.
- Z14-Recommendation of payment has been based on this procedure code which best describes services rendered.
- ZLG-This bill has been reviewed by a registered nurse.
- F-Reduction according to fee guidelines.

Explanation of Benefits dated March 15, 2005

- F-Reduction according to fee guidelines.

Explanation of Benefits dated July 22, 2005

- Upon reconsideration of this bill, the above reimbursement determination has been made. The previous audit determination for this bill was \$0.00.
- X20-Documentation shows hospital stay exceeds 23 hours.
- Z14-Recommendation of payment has been based on this procedure code which best describes services rendered.
- ZLG-This bill has been reviewed by a registered nurse.
- F-Reduction according to fee guidelines.

Explanation of Benefits dated January 5, 2006

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- W1-Workers compensation state fee schedule adjustment.
- Upon reconsideration of this bill, the above reimbursement determination has been made. The previous audit determination for this bill was \$0.00.
- X20-Documentation shows hospital stay exceeds 23 hours.
- Z14-Recommendation of payment has been based on this procedure code which best describes services rendered.
- ZLG-This bill has been reviewed by a registered nurse.

Explanation of Benefits dated January 6, 2006

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- W1-Workers compensation state fee schedule adjustment.
- Upon reconsideration of this bill, the above reimbursement determination has been made. The previous audit determination for this bill was \$0.00.
- X20-Documentation shows hospital stay exceeds 23 hours.
- Z14-Recommendation of payment has been based on this procedure code which best describes services rendered.
- ZLG-This bill has been reviewed by a registered nurse.

Explanation of Benefits dated January 16, 2006

- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- W1-Workers compensation state fee schedule adjustment.
- Upon reconsideration of this bill, the above reimbursement determination has been made. The previous audit determination for this bill was \$0.00.
- X20-Documentation shows hospital stay exceeds 23 hours.
- Z14-Recommendation of payment has been based on this procedure code which best describes services rendered.
- ZLG-This bill has been reviewed by a registered nurse.

Findings

1. The respondent denied reimbursement for the disputed services based upon "X20-Documentation shows hospital stay exceeds 23 hours."
28 Texas Administrative Code §134.401(b)(1)(B), states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."
A review of the submitted medical bill and itemized statement, indicate that the requestor billed for outpatient services. The Division finds that the requestor billed for 30 hours of observation, as well as other services related to the surgery; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B).
2. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
3. The respondent denied reimbursement for the disputed services based upon "Z14-Recommendation of payment has been based on this procedure code which best describes services rendered," and "150-Payment adjusted because the payer deems the information submitted does not support this level of service."
The respondent further clarified the denial in the March 2, 2005 letter stating that "Therefore my recommendation is that Las Palmas Medical Center needs to submit a corrected claim (inpatient; bill type 111) with a Room and Board Line so this bill can be reimbursed at the per diem rate."
28 Texas Administrative Code §134.401(b)(2)(E) states "All bills for acute care hospital inpatient services shall be submitted on form TWCC-68a, the standard UB-92 (HCFA 1450) form. Depending upon the type of service(s) rendered, the appropriate code shall be included on each UB-92 (HCFA1450) submitted."
28 Texas Administrative Code §134.800(a) states "Except as provided by §134.801 of this title (relating to Submitting Medical Bills for Payment), health care providers shall submit medical bills for payment on

standard forms used by the Centers for Medicare and Medicaid Services (CMS) or applicable forms prescribed in subsection (b) and (c), completed in accordance with Commission instructions. All information on medical bills shall be legible when submitted.” According to CMS the three digit national Uniform Billing Committee (NUBC) code used in box number four identifies the type of bill. The first digit identifies the type of facility, number one is to be used by hospitals. The second digit classifies the type of hospital: a “3” identifies the facility as outpatient; and “1” as inpatient.

A review of the submitted medical bill indicates that the requestor coded the admission as “131” on the original bill and “137” on the subsequent bill. The requestor incorrectly billed this admission as an outpatient hospital admission per CMS instructions, 28 Texas Administrative Code §134.401 and §134.800.

4. The respondent denied reimbursement for the disputed services based upon “W1-Workers compensation state fee schedule adjustment.”

28 Texas Administrative Code §134.401(c)(1) states “Standard Per Diem Amount. The workers’ compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical \$1,118.”

A review of the submitted medical bill indicates that the requestor billed for surgical services.

28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is “LOS X SPDA = WCRA.” Therefore 1 multiplied by \$1,118.00 = \$1,118.00. The respondent paid \$0.00. Therefore, the difference between the MAR and amount paid is \$1,118.00. This amount is recommended for reimbursement.

5. 28 Texas Administrative Code §134.401(c)(4), states “Additional reimbursement. All items listed in this paragraph shall be reimbursed in addition to the normal per diem based reimbursement system in accordance with the guidelines established by this section. Additional reimbursement apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.”

28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).”

The requestor billed \$11,490.59 for supply/implants under revenue code 278. The respondent specifically requested copies of implant invoices in the March 2, 2005 letter. The Division finds that the requestor did not submit cost invoices at the time of billing or in the dispute packet to support position that additional reimbursement is due; therefore, reimbursement cannot be recommended for revenue code 278.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation support the reimbursement amount of \$1,118.00 sought by the requestor. As a result, the amount ordered is \$1,118.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1118.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

01/04/2012

Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.